SOCIETY OF MEDICAL OFFICERS OF HEALTH

National Health Service Act, 1946

HEALTH CENTRES

Report by a Special Committee of the Council of the Society of Medical Officers of Health

Presented to the Council 19th September, 1947

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National Health Service Act, 1946

Health Centres

In July, 1946, the Council of the Society of Medical Officers of Health appointed a special committee to furnish a report on health centres under the National Health Service Act.

The constitution of the Committee, which was given power to co-opt, was as follows:—

Chairman (elected by the Committee):

Professor R. H. Parry, M.D., F.R.C.P., D.P.H. (M.O.H., City of Bristol: Professor of Preventive Medicine, University of Bristol).

Other appointed members:

Sir Allen Daley (President of the Society, 1946-47: M.O.H., County of London).

Dr. G. F. Buchan (Chairman of the Council: formerly M.O.H., Willesden M.B.).

Dr. W. A. Bullough (County M.O.H., Essex).

Dr. Katherine Hirst (then Sen. A.M.O.H., Islington Met. B.).

Dr. Arthur Massey (then M.O.H., Coventry C.B.).

Dr. A. A. E. Newth (Sen. School M.O., Nottingham C.B.).

Dr. H. C. Maurice Williams (M.O.H., Southampton C.B.).

Members Co-opted by the Committee:

Dr. Frank Gray (B.M.A.).

Dr. G. Hamilton Hogben (M.O.H., Tottenham M.B.).

Mr. A. Gordon Taylor (D.O., L.C.C.).

Secretary: Mr. G. L. C. Elliston, M.A.

The terms of reference were:—

"To explore and report on the functions and design of Health Centres to be provided under the National Health Service Act."

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Preamble

1. Medical Officers of Health of Local Health Authorities, since the publication of the National Health Service Bill last year, have been confronted with requests for advice to their Councils on the number and size of sites which would have to be reserved for Health Centres in connection with new housing and health service development plans.

2. The Council of the Society of Medical Officers of Health therefore decided to appoint a special committee, whose members are listed on the opposite page, to explore and report on the functions and design of the Health Centres to be provided under the National Health Service Act.

3. The Committee has held four meetings and now presents its report. In this report the main emphasis is placed on the functional aspect, as clearly the actual design of individual Centres will vary according to local factors such as policy, density of population, the demand from general practitioners for accommodation, the building situation, and so on. The Committee has become convinced of the need for a period of experimentation in different areas according to the differing conditions in those areas before any general construction of Health Centres is entered upon. This report therefore explores in a general way the various activities which may require to be housed in various types of Centre according to local needs. Examples and statistics quoted are drawn from the experience of members of the Committee in Health Centres already provided for local authority services only, and should not be taken as rigid or definite indices of future requirements. The report does not attempt to lay down any single policy or method as the only correct one in connection with Health Centres, but mentions alternative points of view as expressed by individual members of the Committee.

4. The Committee is unanimous in recommending that Health Centres should be new buildings especially designed for the purpose, and not be improvised by the adaptation of existing buildings. It is felt that public health activities have suffered in the past from being housed in old and unsuitable premises, so that the environment of welfare centres or school clinics has been completely at variance with the objects of the services which are provided. Paragraphs 11 to 40 refer to considerations in planning for a combined Health Centre for a population unit of 8,000 to 10,000 in an urban area, and paragraphs 50 to 53 mention special considerations in planning rural Health Centres. Paragraphs 54 to 58 point out, with regard to design, what departments may be comprised in a Health Centre and the accommodation required, but do not go into such details as floor space required and construction.

Definition

5. Health Centre is a name which has been applied to premises the function of which have varied considerably both in different parts of the country and at different periods in the same district. But a definition has now been expressed in the National Health Service Act, 1946. Section 21 of the Act places on every local health authority, *i.e.*, the councils of counties and county boroughs, the duty of equipping, maintaining and staffing, to the satisfaction of the Minister, premises to be called Health Centres at which facilities shall be available for all or any of certain specified purposes, namely :—

The provision of

(*a*) general medical services by medical practitioners, and

(*b*) general dental services by dental practitioners under Part IV of the Act ;

except that a local health authority shall not employ medical or dental practitioners at Health Centres for the provision of these services under Part IV of the Act ;

(*c*) pharmaceutical services under Part IV of the Act by registered pharmacists ;

(*d*) any of the services which a local health authority are required or empowered to provide ;

(*e*) service of specialists or other services provided for out-patients under Part II of the Act ;

(*f*) the exercise of the powers conferred on the local health authority for the publication of information on questions relating to health or disease, and the delivery of lectures and the display of pictures or cinematograph films in which such questions are dealt with.

6. In the White Paper on a National Health Service (Cmd. 6502, February, 1944), reference was made to Health Centres as follows : " Scope must be given (with central and local professional guidance) to experiment and to design capable of later adaptation. Broadly, the design should provide for individual consulting-rooms, for reception and waiting rooms, for simple laboratory work, for nursing and secretarial staff, telephone services and other accessories, as well as—in varying degree according to circumstances—recovery and rest rooms, dark rooms, facilities for minor surgery, and other ancillaries. The object will be to provide the doctors with first-class premises and equipment and assistance and so give them the best facilities for meeting their patients' needs."

7. Local authorities and voluntary bodies have had experience in administering Health Centres (not always so described) for their own special services. Doctors have seen patients at

such centres for diagnosis and treatment, *e.g.*, under schemes for tuberculosis, maternity and child welfare, school health services, and venereal diseases; dentists have been similarly employed at Health Centres. In fact, it may be said that of the functions mentioned in the Act, all, except those of group practice, have been carried out in these centres, so that the problems of functions and design are discussed with some knowledge of the difficulties which are encountered in their administration, and of what is wanted and what is to be avoided. For example, there has been in the past a tendency to economise in the number of rooms so that there is no spare accommodation to meet fluctuating demands for additional or special sessions : a suite of rooms has been put to too many alternative uses so that it needed to be furnished and equipped in excess of requirements for a single purpose, resulting in loss of control over equipment and apparatus. Size and arrangement of rooms are questions of design on which opinions based on experience have been formed. It has been emphasised that future arrangements must tend towards greater privacy and less mass dealing with patients.

8. On general principles, if full benefit of Health Centre provision is to be attained, it would be advantageous if all services could be brought together on the same site. From the medical aspect, if the work of the general medical services is to be conducted from Health Centres, then the provision of aids to diagnosis should be considered. In fact, experiment must be in the direction of expanding facilities, and not in the direction of limiting them.

9. In the past the name Health Centre has meant usually a local authority health centre providing the clinic services of maternity and child welfare and school health, although in particular instances this has been extended to include accommodation for other allied public health functions.

10. Under the National Health Service the name Health Centre will apply to a building housing either (1) the local authority health services only; (2) general medical and dental or specialist services under the Act; or (3) all the services above mentioned. When the total area requires the provision of all the services under the Act it may be advantageous from the point of view of public recognition and convenience to house all the services in one building, or at least within the same curtilage : such a step would also help to integrate the services. The factors of local geography, including distance, accessibility and the pros and cons of housing the public health and general medical service facilities in the same premises are further discussed below.

CONSIDERATIONS IN PLANNING A COMBINED HEALTH CENTRE IN AN URBAN AREA FOR A NEIGHBOURHOOD UNIT

Units of Population to be Served

11. We considered as a first step what is the minimum population using a Health Centre which will provide an adequate demand for all or any of the services available at a Health Centre. The example of demand for local authority health services given below (para. 12) has been prepared on the basis of a population of 10,000, and assuming a 100% user, except in the case of school health services where a 75% user has been assumed. Our experience confirmed that well equipped modern premises conveniently situated attracted a high percentage of the potential attenders. It seems reasonable, therefore, to expect a similar high proportion of attenders at the Health Centres of the future if they serve fairly compact neighbourhood units. Moreover, the universality of the insurance services under the Act will tend to eliminate any distinction between payers and non-payers, so that it is to be expected that in the long run the great majority of the public will use Health Centres.

[As an illustration, it was reported that in one large town during 1946 the actual percentages of attenders at clinics for certain services were as follows :—

Ante-natal services ...	Approximately 75% of expectant mothers.
Post-natal	Approximately 25% of nursing mothers.
Consultant ante-natal	Approximately 40% of ante-natal clinic attenders.
Infant welfare ...	Approximately 55% of children under one year.
Child welfare ...	Approximately 15% of children one year to five years.
School health service (including dentistry)	Approximately 65% of numbers on register.]

12. The following table relating to a population of 10,000 for one Health Centre is based on a birth-rate of 18 per 1,000 population, stillbirths 40 per 1,000 total births, and infant deaths 40 per 1,000 live births. Some allowance has been made in the figures in the table for public and school holidays, but there is no allowance for deviation from an average even flow of patients from week to week. Apart from new patients, it is anticipated that an appointment system will space out attendances within limits. The figures in the table assume a 100% user of the services mentioned, and that the services will be organised by sessions held in clinics. The only excep-

tion is the school health service, where a 75% user has been assumed.

Service	Attenders per 10,000 population	Expected number of attendances per annum		Average number attenders per week	No. of attenders per session (half-day)	No. of sessions required per week
		Per patient	Total			
Maternity—						
Ante-natal	200*	12	2,400	48	12–15	4
Post-natal	200	3	600	12	6–8	2
Infant Welfare—						
Under 1 year	180	17	6,560	130	20–25	6
Over 1 year	700	5				
School Health	1,500	6	9,000	180	20–25	8
Total number of sessions required per week						20+

* Including abortions, etc.

Notes.

(*a*) In regard to ante-natal sessions, it is considered that the actual period devoted to examination of patients should not exceed two hours. This leaves the doctor time for reflection and study of particular cases and for dealing with correspondence. Some patients—new and special cases—may require as long as 20 minutes to half an hour for examinations, whilst others can be seen in a few minutes. On average, a figure of 12 to 15 patients per two hours session is thought to be reasonable.

(*b*) A post-natal patient should not require more than five attendances—a condition which has not been satisfactorily dealt with by then is a case for reference to the specialist clinic. An average of three attendances per patient has been assumed and the number of patients per session from six to eight.

(*c*) Regarding infant welfare clinics, it has been assumed that with doctor and nurse working together, 20 to 25 children can be seen at a session of two hours, 15 to 18 of these only being sent on to the doctor.

(*d*) The number of children attending from school will vary from area to area according to type of district and to policy as to holding sessions in the schools themselves, but an average has been taken for this purpose.

13. It will be seen from the foregoing tabulation that suites of rooms providing facilities for routine maternity and child welfare and school health services will be occupied to the extent of 20 session periods out of a possible 22, the accommodation on the remaining periods being available for an occasional consultative clinic or other purpose. It will also be seen that there is sufficient work here for the equivalent of two doctors working together—a combined maternity and child welfare and school health centre. The maximum population which can be served by such a Health Centre providing facilities for use on the above lines is therefore about 10,000, but might preferably be about 8,000.

14. A view was expressed that provision of Health Centres for population units of 8,000 to 10,000 was unduly liberal and that one divisonal centre for a much larger population, say 40,000 or more, with satellite centres for local general medical and dental services, was a more practical proposition.

15. The Committee agrees that if the policy of restricting a Health Centre to a maximum population of 10,000 is accepted, the requirements of a larger population would have to be met, either by multiplying the services at one building or by dividing the area to be served into two or more separate Health Centre districts. It would usually be desirable from the point of view of distance to provide two separate Health Centres for public access. In a very thickly populated and densely built-up area, however, *e.g.*, where 20,000 people might be living within a radius of only a quarter of a mile, the distance factor would lose its significance ; other factors, such as scarcity of building land and economy in construction and operating costs, would decide in favour of duplication of Health Centre facilities on a single site.

16. It will probably be agreed that a population of less than 3,000, able to support such a Health Centre for local authority services for less than half-time, would not justify, of itself, the provision of a special building for this purpose ; but the grouping of other community services on a sharing basis might bring it within economic reach. This problem is likely to occur infrequently in an urban area where only occasionally the geographically isolated small community is found. On the other hand, it will be more difficult to space Health Centres in rural areas, so that sufficient population is included in a " catchment area " which is not so large that people cannot conveniently reach the centres.

17. We next considered how this population-standard, applicable to the routine or regular localised local authority health centre service, would operate in regard to the localised medical practitioner general medical services to be rendered in the Health Centre, either by doctors working singly or in groups.

18. In the *Lancet* of January 11th, 1947, it was estimated that an even distribution of the present complement of general practitioners would suffice to provide one doctor for every 2,200 people, but this estimate does not allow for the varying distribution of doctors in urban and rural areas. An approximate figure might therefore be taken of 2,400 to 2,500 per doctor and four to five doctors for a general medical service Health Centre, supported by a population of 8,000 to 10,000 in an urban area. If individual consulting rooms and waiting rooms are provided, there is—without reference to other factors—no limit to the number of doctors who might work at a single Health Centre. However, it is suggested that this number of medical practitioners represents a satisfactory number for working together in group practice. (See paragraphs 30 to 34.) It is likely for social reasons that it will be in the most densely populated areas that there will be the most urgent need for medical practitioners to establish their surgeries in Health Centres while they reside elsewhere within or outside the area.

19. We have dealt so far with the population basis for a Health Centre which provides services within easy reach of local population, and our conclusion has been that a single Health Centre, comprising a public health service wing and a general medical and dental service wing, would best serve a population of from 8,000 to 10,000. This size of population is that generally envisaged in town planning proposals for a "neighbourhood unit," a community provided with its own civic services, *e.g.*, churches, community centre, schools, libraries, Health Centres, swimming baths, places of entertainment and shopping centre.

20. The next question arises : To what extent should certain services, which are provided only in some of the Centres throughout the whole area of the local authority, be grouped with those of adjacent populations ? To do this is a desirable economy.

21. In regard to dental treatment for school children and expectant mothers and nursing mothers and for children under five, there are certain advantages in local authority dentists working in pairs rather than singly, and for two surgeries to be provided at Health Centres for that purpose. On the assumption that a school child population of 2,500 (excluding specialist, *e.g.*, orthodontic, work) and the priority

classes, expectant and nursing mothers and children under five years, will provide sufficient work for one dentist, a combination of two Health Centre areas with a school population of 4,000 to 5,000 (total population 20,000 to 25,000) would be necessary for two full-time dental surgeons in a double-dental surgery suite. Alternatively, with the introduction of orthodontic and more elaborate conservative treatment, the ultimate goal may be in the region of one dental officer per 2,000 pupils—which is the school population of a neighbourhood unit. In that event a single surgery could be fully engaged with the demand from one Health Centre area. A view has been expressed that it would probably improve the efficiency of this service still more if the dental surgeon worked in the school and not at the Health Centre ; but such an arrangement is criticised on the ground that it is bad to divide the population into arbitrary classes so as to break up family treatment. In addition, a dental officer limited to a children's practice becomes a specialist with too limited a field of work.

22. A population of 10,000 might be expected to create a demand for general dental services of three dental practitioners. This is sufficient to warrant the establishment of a group of two or three dentists singly, or in group practice, at each Health Centre in the medical-care section, in addition to that provided by the local authority. Naturally there will be difficulty in adjusting demand and supply as between one Health Centre area and another, so as to maintain optimum use of the facilities and staff provided ; but this can be minimised by appropriate groupings and rotas as may be required in the circumstances. The advantages of one or more mobile surgeries for certain areas should not be overlooked. It has been pointed out that dentistry is not necessarily a neighbourhood service ; and, as in North America, it might be provided with the medical consultant's services from centralised surgeries. In any event, provision should be made for access to *x*-ray services and laboratories for the making of dentures and orthodontic appliances.

23. If other specialist services are to be provided at the Health Centre (for example, ear, nose and throat, eye, orthopaedic) they will be dependent on a much larger population to provide the most convenient number of cases. But it will usually be found that a combination of Health Centre areas to give a total population of 70,000 to 80,000, will be sufficient to support special provision at one main Health Centre, as distinct from decentralising by the occasional use of facilities at any Health Centre used alternatively and usually for other purposes.

24. So far we have ascertained the appropriate size of population groups with reference to the provision of facilities for the main services. Auxiliary provision (for example, *x*-ray, dental, sunlight, laboratory service, etc.), is not directly related to population, because the demand for these is derived from the main services, and so the extent of their provision is controlled by this and other considerations discussed later in this report.

25. It has been proposed that Health Centres for the local authority services in urban areas should be so spaced that a mother need not have to push a loaded pram more than about half a mile. If adopted this would mean that few patients attending for regular treatment or advice would be obliged to travel a much greater walking distance than this from their homes. This distance factor would not apply where the less frequently used specialist and other services are in question. Here a much larger population is required to produce an adequate demand ; and a measure of concentration is necessary in the interests of economy of specialist staff and equipment.

26. It will be found that in many urban areas a radius of approximately half a mile will describe a boundary enclosing a population of from 6,000 to 10,000, according to local density, matching very nearly the optimum population figure previously determined for the local public health services.

27. Special features of the district have to be taken into account and will be a cause of deviation from the standards of population and distance. Local authorities will also require to take into account existing Health Centres. The possibility of making temporary provision in old premises suitable for adaptation, pending a new building programme, is not favoured by the Committee. (See our remarks in paragraph 4 above.)

Siting

28. The guiding principle in selecting the site for a Health Centre will be maximum public advantage, having regard to long-term planning. It is fortunate that the population standard suggested for a Health Centre area corresponds so nearly with modern planning view that a neighbourhood unit is of about 10,000 people. When a new neighbourhood is being planned the opportunity should be taken to site the Health Centre with other civic buildings at the centre of the unit.

29. It will be found that most of the main activities of the community fall within a half-mile radius and it is a good thing if the members of the family find their various interests—Health Centre, school, swimming baths, library, local shopping centre, community centre, etc.—fairly close together. The municipal departments might also find it economical to share facilities ; for example, heating and caretaking. There should be adequate space for car parking.

30. The ideal can be attained in the planning of new districts. But in built-up areas there is likely to be considerable difficulty in finding an open site or one suitable for redevelopment; and this is one reason for duplicating the provision on a single site when a radius of less than a quarter of a mile still provides a population considerably in excess of the maximum for a single-unit Health Centre. It is quite probable, in fact, that in built-up areas the standards adopted in this report will need to be considerably modified. For example, the necessary flexibility might be achieved if a considerably larger population were served by one main Health Centre, housing the specialist services, and supported by satellite Health Centres comprising only waiting and consulting rooms, with perhaps a dispensary for the general practitioner service. (See also paragraph 14.) The main Health Centre would provide specialist facilities.

Functions

31. The foregoing paragraphs were necessary before discussing fully the functions of a Health Centre. It has been shown that a population of 8,000 to 10,000 within an urban area of approximately 300 acres, excluding large open spaces, will support Health Centre units for :—

(*a*) general medical services (approximately four medical practitioners) ;

(*b*) general dental services (two to three dental practitioners) ;

(*c*) certain local authority services (maternity and child welfare and school) ;

(*d*) possibly certain specialist services.

32. Before proceeding, it is necessary to say more about the question of the number of medical and dental practitioners to work in one Health Centre. The numbers given above were arrived at on a population basis and it was found that this provided about as many attenders as could be dealt with reasonably at a single centre.

33. If the doctors (or dentists) work as independent practitioners in a Health Centre, merely making use of the modern accommodation, equipment and staff of the centre, the number working under the same roof will not affect them. On the other hand, if they are to operate as one unit in group practice or partnership, consideration needs to be given to the best number suited to that purpose—how many are necessary to make effective co-operation possible ; and how many more added to the group will diminish rather than increase co-ordinated effort ?

34. A relatively small group of practitioners may be sufficient to cover all the normal needs of reliefs for holidays and

sickness. A small group may also include men of sufficiently diverse interest and character to allow for reasonable division of work and specialisation if it is wanted and desired, and also to allow a reasonable measure of choice of practitioner to the patient. The question of specialisation amongst general practitioners is highly controversial. Arguments adduced against the view that there should be such diversion of work include (*a*) that a full specialist service will be available to the general practitioner when required, and (*b*) that general practice of itself is specialisation and that engagement in other fields may be to the detriment of the general practitioner's own proper functions. On the other hand, it is suggested that a bias by a doctor towards a specialism should be encouraged in the interests of making his special aptitude more fully available. Probably experiment will lie in either direction according to the local view.

35. We have also concluded that the public advantage is served by establishing these Health Centre units with the several activities on the same site. If the purpose of providing Health Centres were confined merely to such redisposition of facilities, then the purposes of the National Health Service Act—increased efficiency through the provision of better and more readily available resources of equipment and staff, greater economy in use and increased co-ordination—would remain unfulfilled.

36. On this basis, discussion can proceed as to how far it should be the function of the Health Centre to provide certain auxiliary units for the full development of these services, and also facilities for certain ancillary services in the field of public health. It will be understood at once that only if the departments are housed in the same building, although they may be in separate wings, will it be possible to have full co-ordination and joint use of facilities, whether these be pharmaceutical services, *x*-ray, laboratory, staff, both nursing and clerical, provided by the local authority, or again such facilities as library, common room and canteen. Only on the basis of joint use can most of these facilities be justified: separation, involving duplication, would prove prohibitive in cost.

37. The point of view has been expressed that mothers bringing their children to a Centre for regular supervision and educational advice should not be mingled in the waiting room with the sick or ailing people who are waiting to see the general practitioners whose consulting rooms are in the same Centre. This raises the question of organisation of the work to be carried on in the Centre. It is possible to separate the different groups of people, without multiplying the facilities, by organising the services and by arranging different times for the people to attend.

Pharmaceutical Services

38. Facilities for the provision of general pharmaceutical services is one of the principal Health Centre functions named in the Act. It is likely that, wherever a group of practitioners is established in a Centre, that the provision of a dispensary in the charge of a full-time qualified pharmacist will be justified and will also be available to meet the limited requirements of the local authority services. On the other hand, the procedure of serving the prescription on the private pharmacist may continue, the only provision in the Health Centre then being a drug store containing standard preparations.

x-ray Facilities

39. Arguments have been adduced in support of the contention that the diagnostic radiological service should be centralised in the hospital specialist department where the services of the consulting radiologist and the fullest range of equipment are always available. It is said that only in this way can the highest skill and the best equipment be fully utilised ; that decentralisation to Health Centres would inevitably mean the provision of inferior or obsolescent equipment ; and that on the whole the general medical practitioner is not sufficiently skilled in radiological diagnosis to benefit from such provision. On the other hand, it is pointed out that it is part of the medical practitioner's training to diagnose the condition of his patient, that the availability of appropriate apparatus on the spot would be of considerable benefit and assistance to both doctor and patient. It is maintained that the provision of such services would not discourage reference of special cases to the consulting radiologist either at the hospital centre or at a consultant's session arranged at the Health Centre.

Laboratory Service

40. Here again the case has been argued for centralising the service in the main laboratory for the district where the highest degree of specialism is available and where the fullest range of equipment can be provided economically. It has also been suggested (*Lancet*, January 5th, 1947) that where there is a group of six or more doctors working together in the same building there seems to be a case for providing a pathological laboratory with full-time technician linked to, and under the supervision of, the main laboratory to undertake all routine bio-chemical, many haemological and some bacteriological examinations. A further alternative suggestion is the provision of small laboratory accommodation where the doctor can carry out investigation on his own.

Casualty Department

41. At the Health Centre it will be necessary to provide a

special department where the medical practitioner may deal with casualties brought there, and where minor operations may be carried out. It is to be anticipated that the improved facilities available at a Health Centre will enable cases discharged from in-patient or out-patient specialist departments of hospitals more readily to continue and conclude their treatment at the Centre.

Other Facilities

42. In addition to the above chief departments, the functions of the Health Centre will include the furnishing of other auxiliary facilities necessary to its working. The local authority maternity and child welfare and school clinics have already a pattern in regard to staffing. Nursing staff assist the doctors at their sessions ; or in some cases the nurses (and midwives) themselves are responsible for the treatment or advice under the general direction of a doctor, thereby releasing the doctor for other work.

43. This same aspect would apply to the general medical and dental service section of the Centre, where several doctors working independently together would receive considerable assistance from qualified nurses made available under the local authority's staffing arrangements as part of the facilities it is required to provide.

44. Similar arrangements apply in regard to the appointment of clerical staff and the establishment of records departments. How far this staff will be interchangeable between the departments and how far the records might be regarded as being available for the common reference of all departments are matters of first importance to the full integration of the service. One thing is certain, that unless the records department is properly established there can be no satisfactory progress towards developing the collection and analysis of morbidity statistics.

45. On the local authority side, it is most important that the health visitor and the sanitary inspector for the district shall have their local headquarters at the Centre, whilst provision should also be necessary in some instances for domiciliary nurses, midwives, and other officers of the Local Health Authority. Regarding the midwife, it is quite clear that, as the focus of the district health services, the Health Centre is her headquarters ; whether she lives at her home, in a hostel specially provided for a group of midwives, or in a flat attached to the Centre (and there is much to be said for this last). It is to the Health Centre that the patient will turn, in the first instance, for full information and directions on health problems ; in the case of midwifery, for example, for booking for antenatal care and for calling the G.P. obstetrician and midwife.

The usefulness of the Centre in smoothing administration is shown by its ensuring that the relief midwife is known and may be found when wanted.

46. Common room, conference room, library and canteen facilities shared by all working at the Health Centre apart from their direct functions are means of fostering the corporate life of the Centre, and so of encouraging co-operation and complete integration of the services.

47. The local health authority's powers, conferred under the 1936 Act, to engage in the work of health education, are continued under the present legislation, which provides that facilities shall be available at Health Centres for such purposes as the publication of information, lectures, and the display of pictures and films. It is not expected that this work will be confined solely to the local authority. There is scope here for educational work from all the staff of units at the Centre who have a contribution to offer.

48. There is a further unit which should be added to the Health Centre—a nursery unit. This unit need not necessarily replace the normal local authority day nursery provision for the babies of the working or sick mother, but would be available for accommodating for a short period the babies of mothers visiting the infant welfare clinic or the general medical and dental service section or for relieving the mother of the custody of the child for such short period in other approved circumstances.

49. It will be within the functions of the Health Centre system to provide a 24-hour telephone service for the purposes of the health services, including calls for doctors, midwives and ambulances, thus making possible "on call" instead of "stand-by" duty, with consequent saving of time. The telephone service would presumably be centralised during the night hours.

CONSIDERATIONS IN PLANNING RURAL HEALTH CENTRES

50. Apart from occasional reference to rural circumstances, this report has been framed up to this point by reference mainly to the conditions operating in an urban area where the problems of concentrating sufficient demand to support the full provision of Health Centre services are largely solved by the greater density of population as compared with rural areas. In Gloucestershire, in 1931, for example, when the last census was taken, the average density of the population in county boroughs was approximately 16 persons per acre, in other urban authorities 4·5 per acre, and in rural districts 0·30 persons per acre.

51. It will be seen immediately that full-time Health Centres performing all the functions described in the preceding estimation will be relatively few and far between. They will be, naturally, near the principal concentrations of population in the county where (say) not less than 3,000 people (*i.e.*, the minimum population required for a Health Centre) are within half a mile radius and a further 3,000 to 5,000 would be brought in at a distance of another mile. In this way the main centres of population (*i.e.*, the majority of persons in the county) will have access to a Health Centre providing all the general services all the time. This will leave small pockets of population to be provided for by subsidiary Health Centres providing limited services at limited times and manned by staff allocated from the main full-time Centre for the district.

52. In the case of large and densely populated urban areas, it has been assumed that hospitals will be readily accessible; therefore, except for certain decentralised consulting clinics, all facilities properly determined as within the functions of a hospital will be excluded from Health Centres. In rural areas where the hospital is not readily accessible, the Health Centre functions will need to be extended to include greater provision for emergency treatment.

53. A plan for the health services for rural areas was formulated by the surveyors of the Hospital Services of Berkshire, Buckinghamshire, and Oxfordshire, and reference may be made to their report for details.

DESIGN

54. We are now ready to list completely the services for which facilities are required, together with the details of such facilities. The marshalling or grouping of the facilities is a necessary preliminary and part of the procedure for arriving at a design for a Health Centre, and at this stage we must remember such matters as storage, caretaking, heating, lighting, etc.

55. The design of the Health Centre must take into account, ideally: First, the broad functions of the units brought together. Secondly, the degree of separation necessary or desirable in administering those functions. Thirdly, the detailed list of facilities must be worked out and their relative location within the building established to provide the most efficient layout. Fourthly, the design must be pleasing and characteristic, but any suggested standard must be sufficiently flexible to avoid universal uniformity and to enable the particular attributes or deficiencies of a given site to be used opportunely and to the best advantage.

56. General guidance on site area requirements given last year by the Chief Medical Officer, Ministry of Health, with

the proviso that the dimensions stated would not allow for a very generous margin of vacant space round the actual buildings, was :—

	Sq. yds.
Health Centre only	1,500
Health Centre with M. & C.W. and S.M.S.	3,300
M. & C.W. and S.M.S. only	2,000
Health Centre, corner site	1,425
Health Centre, rural	950
Diagnostic Centre, single storey	3,300
Diagnostic Centre, two-storey building ...	2,100

(It would appear that the words "Health Centre" in the above list mean a building provided for general practitioner services only.)

57. The main departments which may be required in a Health Centre, and their relationship to each other, may be diagrammatically represented as follows :—

HEALTH CENTRE

Local Health Authority
Ante-Natal Clinics Post-Natal Clinics Infant Welfare Clinics School Health Clinics Minor Ailments Dental Clinics
Officers of Local Authority
Health Visitor Midwife District Nurse General Offices Central Offices

General Medical and Dental Service
Medical Practitioners Casualty Department Dental Practitioners
Observation beds in certain rural areas

Joint Facilities
X-ray Dispensary Laboratory Records Library Common Room Canteen

58. The accommodation which may be required for these departments is listed below :—

HEALTH CENTRE ACCOMMODATION

General Provision

Entrance hall
General waiting room
Doctors' common room
Kitchen and canteen
Lecture hall and demonstration room
Chief clerk's or secretary's room
General office
Enquiries office
Records office (main and subsidiary)
Pram shelter
Domestic store and cleaners' room
Stores
Health visitor's room/midwife/district nurse
Sanitary inspectors' room
Telephone exchange
Lift
Caretaker's flat
Boiler house
Lavatory accommodation
Garages and parking space
Midwife's flat
Staff common room
Staff library
Staff kitchen and canteen

Maternity

Doctor's consulting room (at least one)
Samples test room
Dressing cubicles
Waiting rooms
Interviewing rooms

Child Welfare

Doctor's consulting room
Special lecture and demonstration room
Waiting room
Nursery and toddlers' room
Toy store
Tests room
Milk room
Playground

School Health

Doctor's consulting room
Nurses' room
Minor ailments room
Waiting room
Dressing cubicles
Isolation room

Other Departments

Dental surgery
,, recovery rooms
,, waiting rooms
Records and attendant's room
Stores
Eye room
x-ray room
,, dark room
,, film store
,, waiting room
,, dressing cubicles
,, records and attendant's room
Dispensary
Dispensary drug store
Laboratory
Laboratory store
Sunlight room
Sunlight dressing cubicles
Orthopaedic and remedial exercises
Orthopaedic dressing cubicles
Foot clinic
Foot waiting room
Cleansing
Child guidance
Speech therapy

General Medical Service

Entrance hall and enquiries
Doctors' consulting rooms
Examination rooms
Waiting rooms
Nurses' room
Records office
Eye room
Stores
Isolation room
Night doctor's room
Casualty Dept.—
  Consulting rooms
  Minor operations room
  Waiting room
  Dressing room
Sterilising room
Isolation room

General Dental Service

Dental surgeries
,, waiting room
,, recovery rooms
Office and records
Dental laboratory
Dark room for dentist

Observation Beds (certain rural only)

Ward
Nurses' room
Lavatories and baths
Stores

Room Dimensions

Mr. D. A. Goldfinch, F.R.I.B.A. (Chief Asst. Architect, (Health) Leeds) in a paper read to the R.S.I. Health Congress, June, 1947, suggested the following :—

Weighing room	300–350 sq. ft., 22 ft. × 16 ft.
Mothercraft room	280 sq. ft., 14 ft. × 20 ft.
Isolation waiting	72 sq. ft., 8 ft. × 9 ft.
Urine testing	72 sq. ft., 8 ft. × 9 ft.
H.V. advising room	150 sq. ft., 15 ft. × 10 ft.
Toddlers' nursery	280–300 sq. ft., 15 ft. × 20 ft.
Collective irradiation	400 sq. ft., 20 ft. × 20 ft.
Dental surgery (extract) ...	190 sq. ft., 12 ft. × 16 ft.
Dental surgery	150 sq. ft., 11 ft. × 14 ft.
Recovery room	72 sq. ft., 8 ft. × 9 ft.
Consulting room (including screened couch)	180 sq. ft., 11 ft. × 16 ft.
Consulting room	140 sq. ft., 9 ft. × 16 ft.
Examination room	64 sq. ft., 8 ft. × 8 ft.
Minor surgery and dressings	300–350 sq. ft., 22 ft. × 15 ft.
Clinical laboratory	110 sq. ft., 11 ft. × 10 ft.
x-ray room	320–350 sq. ft., 24 ft. × 14 ft.
Dark room	100–120 sq. ft., 10 ft. × 11 ft.
Remedial gymnasium... ...	360 sq. ft., 24 ft. × 15 ft.
Minor ailments treatment ...	280 sq. ft., 14 ft. × 20 ft.
Caretaker's flat	750–800 sq. ft

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